

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filled with the funeral director.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11859

CERTIFICATE OF DEATH

11868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>A.</i> Last <i>AMBROSE</i>		4. DATE OF DEATH Month <i>November</i> Day <i>25</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 16 1881</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles H. Eyles</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Weller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mr. John H. Ambrose, Jr., Woodboro, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Arteriosclerotic Cardio-Vascular Disease</i> DUE TO (c) <i>3 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 15</i> , 19 <i>57</i> , to <i>Nov. 25</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Nov. 25</i> , 19 <i>57</i> , and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ernest A. Dettbarn</i> M.D.		DATE SIGNED <i>Nov. 26, 1957</i>	
PHYSICIAN'S NAME (Type) <i>ERNEST A. DETTBARN</i>		<i>Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/28/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>United Brethren</i>		22d. LOCATION (City, town, or county) (State) <i>Thurmont Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Y.C. Barton</i>		ADDRESS <i>Walkersville, Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE 29 Nov. 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth S. Heck</i>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11860 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11860
Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 6 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 158 West All Saints Street				d. STREET ADDRESS 158 West All Saints Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SHEBRA Middle LAWRENCINE Last AMBUSH				4. DATE OF DEATH Month November Day 22 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19, 1957	
9. AGE (In years last birthday) yrs. 1 Months 3 Days 3 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Lawrence T. Davis				14. MOTHER'S MAIDEN NAME Mary Frances Ambush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. David E. Myers- Same as Item #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.4 Acute Cardiac dilation DUE TO Conditions, if any, which gave rise to immediate cause (b) Congenital Heart defect DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						INTERVAL BETWEEN ONSET AND DEATH 	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 26 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck	

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11861

CERTIFICATE OF DEATH

11870

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle LEE Last ARNOLD				4. DATE OF DEATH Month November Day 3 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Oct 1909		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George V. Arnold				14. MOTHER'S MAIDEN NAME Emma M. Ausherman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-3275		17. INFORMANT Address Thomas D. Arnold (Same as Item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute St. Side Lead decomposition 241X DUE TO Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma + Chronic Pneumonia DUE TO (c) Chronic Bronchial Asthma Myocardial degeneration INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old lumbosacral disease with deformity							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 31, 1957 to Nov 3, 1957 , that I last saw the deceased alive on Nov 3, 1957 , and that death occurred at 3 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson, Maryland DATE SIGNED 11-4-57							
ACTUAL SIGNATURE A. T. Brice M.D.							
PHYSICIAN'S NAME (Type) A. T. Brice, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-57		22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery		22d. LOCATION (City, town, or county) (State) Near Burkittsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 6 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

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11862
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 900 Pine Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARA Middle Marsh Last AUSTIN		4. DATE OF DEATH Month November Day 8 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept 1904
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clement Marsh		14. MOTHER'S MAIDEN NAME Louella Foscett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT James R. Austin (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25/57 , 19 57 , to 11/8/57 , 19 57 , that I last saw the deceased alive on 11/8 , 19 57 , and that death occurred at 11:35P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. R. Schoolman		ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 11-9-57	
PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/12/57	22c. NAME OF CEMETERY OR CREMATORY Corbin Cemetery	22d. LOCATION (City, town, or county) (State) Dudley, Mass.
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 12 Nov 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11872

CERTIFICATE OF DEATH

Reg. Dist. No. 138

11892

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Kemptown</u>				c. LENGTH OF STAY IN 1b <u>Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. Monrovia</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rufus</u> Middle <u>E.</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1870</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>	IF UNDER 24 HRS. Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Baker</u>				14. MOTHER'S MAIDEN NAME <u>Jemima Purdum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Emma E. Baker, Monrovia, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, terminal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebro-vascular accident</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>96 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous cell carcinoma left hand</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Nov. 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 16</u> , 19 <u>57</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> DATE SIGNED <u>11/18/57</u>							
ACTUAL SIGNATURE <u>G. F. Meadors, M.D.</u>				PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Kemptown, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Moleworth</u>				24a. REC'D BY REGISTRAR DATE <u>11/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>Raymond L. Day</u>	

18 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 75 MANCHESTER AVE.							
3. NAME OF DECEASED (Type or print) First KATHLEEN Middle J. Last BOWERS				4. DATE OF DEATH Month 11 Day 16 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-18-52	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME JOHN BOWERS				14. MOTHER'S MAIDEN NAME SCATTERGOOD CORDELIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT 75 Manchester Ave. Address NODIE JOHN BOWERS Westminster Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STAPHYLOCOCCAL PNEUMONIA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11-11 , 19 57 , to 11-16 , 19 57 , that I last saw the deceased alive on 11-16 , 19 57 , and that death occurred at 9:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11/16/57							
ACTUAL SIGNATURE Fred W. Helprich M.D.				PHYSICIAN'S NAME (Type) FRED W. HELPRICH M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11-18-57		22c. NAME OF CEMETERY OR CREMATORY MEADOWS SPANCHEN WESTMINSTER MD.	
22d. LOCATION (City, town, or county)				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE David A. Bankard Westminster Md.				24a. REC'D BY REGISTRAR 11-20-1957		24b. REGISTRAR'S SIGNATURE Ely S. Hays	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5. The following are the names of the persons who have been appointed to the various committees of the Board of Directors:

453367

32-31-5

John B. Beck

0-973-3778-2

45794619259

RECEIVED 1977-03-04

BUREAU V. 5

NOV 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11864

CERTIFICATE OF DEATH

11874/21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>15 M</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mc I.O.O.F Home</i>				e. STREET ADDRESS <i>3012 Christopher Avenue</i>			
3. NAME OF DECEASED (Type or print) First <i>Howard</i> Middle <i>Edward</i> Last <i>Bromwell</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>26</i> Year <i>1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 13, 1880</i>	
9. AGE (In years last birthday) <i>77</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paper Hanger</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Louis Bromwell</i>				14. MOTHER'S MAIDEN NAME <i>Anna Brooks</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>216-32-7273</i>			
17. INFORMANT <i>Mrs. Mary L. Bromwell, I.O.O.F. Home</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>chronic myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>to carcinoma prostate</i> (c)				INTERVAL BETWEEN ONSET AND DEATH <i>28 hours</i> <i>2 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Jan. 1</i> , 19 <i>57</i> to <i>Nov. 26</i> , 19 <i>57</i> that I last saw the deceased alive on <i>Nov. 26</i> , 19 <i>57</i> and that death occurred at <i>11:35 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Frederick, Md</i> DATE SIGNED <i>11-26-57</i>			
ACTUAL SIGNATURE <i>Wm. M. Smith</i>				M.D. <i>Frederick, Md</i>			
PHYSICIAN'S NAME (Type) <i>William M. Smith</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/29/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 29 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Ray Beck</i>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

11865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, Film G222 11-25-57 et

Reg. Dist. No. 13

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. STREET OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bartonsville, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William First Middle Last Brown			4. DATE OF DEATH Month Nov. Day 11 Year 1957		
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 11-1893		9. AGE (in years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1st. W.W. 213-16-0581		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stab wound, left side of chest; did not penetrate lung or heart. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11/14/57	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-57		22c. NAME OF CEMETERY OR CREMATORY Fairview	
				22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles E. Hicks 111 Frederick, Md.			24a. REC'D BY REGISTRAR DATE 9 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck

RECEIVED

NOV 20 1957

BUREAU V. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON.

NAME OF DECEASED: [REDACTED]
AGE: [REDACTED]
SEX: [REDACTED]
RACE: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11866

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 50 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 165 B & O Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUSAN Middle DOROTHY Last BURRISS		4. DATE OF DEATH Month November Day 8 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Aug 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Williams		14. MOTHER'S MAIDEN NAME Henrietta Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 219-07-4910	
17. INFORMANT Charles C. Burriss		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-30, 1958 , to 11-4, 1957 , that I last saw the deceased alive on 11-4, 1957 , and that death occurred at 7 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE U. G. Bourne Jr.		M.D. 30 W. All Saints St., Fred'k, Md. 11-8-57	
PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-11-57	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 12 Nov 1957	24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 13 1957

BUREAU V. 3

1. Name of deceased		2. Date of death	
3. Place of death		4. Cause of death	
5. Age at death		6. Sex	
7. Race		8. Marital status	
9. Occupation		10. Education	
11. Date of birth		12. Place of birth	
13. Date of death		14. Place of death	
15. Cause of death		16. Date of death	
17. Place of death		18. Cause of death	
19. Date of death		20. Place of death	
21. Cause of death		22. Date of death	
23. Place of death		24. Cause of death	
25. Date of death		26. Place of death	
27. Cause of death		28. Date of death	
29. Place of death		30. Cause of death	
31. Date of death		32. Place of death	
33. Cause of death		34. Date of death	
35. Place of death		36. Cause of death	
37. Date of death		38. Place of death	
39. Cause of death		40. Date of death	
41. Place of death		42. Cause of death	
43. Date of death		44. Place of death	
45. Cause of death		46. Date of death	
47. Place of death		48. Cause of death	
49. Date of death		50. Place of death	
51. Cause of death		52. Date of death	
53. Place of death		54. Cause of death	
55. Date of death		56. Place of death	
57. Cause of death		58. Date of death	
59. Place of death		60. Cause of death	
61. Date of death		62. Place of death	
63. Cause of death		64. Date of death	
65. Place of death		66. Cause of death	
67. Date of death		68. Place of death	
69. Cause of death		70. Date of death	
71. Place of death		72. Cause of death	
73. Date of death		74. Place of death	
75. Cause of death		76. Date of death	
77. Place of death		78. Cause of death	
79. Date of death		80. Place of death	
81. Cause of death		82. Date of death	
83. Place of death		84. Cause of death	
85. Date of death		86. Place of death	
87. Cause of death		88. Date of death	
89. Place of death		90. Cause of death	
91. Date of death		92. Place of death	
93. Cause of death		94. Date of death	
95. Place of death		96. Cause of death	
97. Date of death		98. Place of death	
99. Cause of death		100. Date of death	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11893

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD #2 Frederick			c. LENGTH OF STAY IN 1b 21 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Jeanne Middle Frances Last Bussard			4. DATE OF DEATH Month Nov Day 11 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1936		9. AGE (In years last birthday) yrs. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME C. Lease Bussard			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		
17. INFORMANT C. Lease Bussard			Address RFD# 2 Frederick, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic glomerulonephritis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial pneumonia severe DUE TO (c) Uremic pericarditis					INTERVAL BETWEEN ONSET AND DEATH unknown 1 wk. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Nov 10, 1957 , to Nov 11, 1957 , that I last saw the deceased alive on Nov 10, 1957 , and that death occurred at 8 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Rex R Martin		M.D. 35 E Church Frederick Md 11-12-57		DATE SIGNED	
PHYSICIAN'S NAME (Type) Rex R Martin					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. [Signature]		ADDRESS Frederick, Md		24a. REC'D BY REGISTRAR DATE 13 Nov 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck					

MEDICAL CERTIFICATION

BUREAU V. S.

NOV 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 131

11867

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				d. STREET ADDRESS DAK ORCHARD ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mr Howard W. Cantwell				4. DATE OF DEATH Nov. 9 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 28-1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL STORE-OWNER-OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
11. BIRTHPLACE (State or foreign country) U. S.				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME LEWIS CANTWELL				14. MOTHER'S MAIDEN NAME SARAH GREEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-32-5672			
17. INFORMANT ANNA M. CANTWELL				Address RURAL MARYLAND NEW WINDSOR			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Coma - Acidosis) DUE TO Broncho-Pneumonia (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 8, 1957 , to Nov. 9, 1957 , that I last saw the deceased alive on Nov. 9, 1957 , and that death occurred at 7 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. A. Pearre M.D.				ADDRESS (Street, city or town, state) FREDERICK, MD			
DATE SIGNED 11/9/57							
PHYSICIAN'S NAME (Type) A. A. PEARRE MD				FREDERICK MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/11/57		22c. NAME OF CEMETERY OR CREMATORY LINGANORE CEM		22d. LOCATION (City, town, or county) (State) UNIONVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Hutzler Sons, New Windsor, Md.				ADDRESS		24a. REC'D BY REGISTRAR 12 Nov. 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

MARYLAND

CITY OF BALTIMORE

WARD 1

STREET ADDRESS

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF DECEASED

NAME OF DECEASED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13113

11868

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 15X2 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick City Hospital				d. STREET ADDRESS 3811 Decatur Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DABNEY Middle JAMES Last CARR				4. DATE OF DEATH Month Nov. Day 30 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 4, 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 3 Days 26		IF UNDER 24 HRS. Hours 26 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Machine shop		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Alban Carr				14. MOTHER'S MAIDEN NAME Emma Agey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 224-26-3860			
17. INFORMANT Caldwell A. Carr				Address same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO (c) 10 yrs +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/27 , 19 57 to 11/29 , 19 57 , that I last saw the deceased alive on 11/29/57 , 19 57 , and that death occurred at 11 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 11/30/57 ACTUAL SIGNATURE Henry V. Chase M.D. Frederick Md PHYSICIAN'S NAME (Type) Henry V. Chase							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 11 1957	
24b. REGISTRAR'S SIGNATURE [Signature]							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11894

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Fred.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Braddock Heights		c. LENGTH OF STAY IN 1b Approx. 3 mos. x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle David Last Crummitt		4. DATE OF DEATH Month Nov. Day 1 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH June 18-1904
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quarry Foreman	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George E. Crummitt	
14. MOTHER'S MAIDEN NAME Mary E. Hanson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-10-1754		17. INFORMANT Mrs. John D. Crummitt-Route 2-Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Breuchogenic Carcinoma 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 16 months			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 1957, to Nov 1 , 1957, that I last saw the deceased alive on Oct 31 , 1957, and that death occurred at 6:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 E. 2nd. St. DATE SIGNED ACTUAL SIGNATURE H. L. Fahrney M.D. PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-3-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick-Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		24a. REC'D BY REGISTRAR DATE 4 Nov. 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		John	
Sex		Male	
Age		35	
Date of death		Nov 15 1957	
Place of death		Baltimore, Maryland	
Cause of death		Heart disease	
Occupation		Salesman	
Manner of death		Natural	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	
Address of informant		[Address]	
City		Baltimore	
State		Maryland	
County		Baltimore	
District		[District]	
Ward		[Ward]	
Block		[Block]	
Lot		[Lot]	
Map		[Map]	
Index		[Index]	
Remarks		[Remarks]	

BUREAU V. S.

NOV 5 1957

RECEIVED

11869

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 2 Weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARY Middle ADELINE Last CULLER			4. DATE OF DEATH Month November 17, Day 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 April 1888	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Morgan H. Rensburg		
14. MOTHER'S MAIDEN NAME Martha A. Pettingall			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Address Paul Z. Culler (Same as item #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary site undetermined DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH undetermined
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 11-06-57 , to 17-11-57 , that I last saw the deceased alive on 17-11-57 , and that death occurred at 3 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church St., Frederick, Md. DATE SIGNED 11-18-57 ACTUAL SIGNATURE Melvin E. Lea M.D. PHYSICIAN'S NAME (Type) Melvin E. Lea, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-57		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	
22d. LOCATION (City, town, or county) Jefferson, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE 19 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11870

CERTIFICATE OF DEATH

Reg. Dist. No.

11881

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK c. LENGTH OF STAY IN 1b 26 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK d. STREET ADDRESS 330 PARK AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EZRA OWEN DORSEY				4. DATE OF DEATH Month Day Year NOV 14 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/18/1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER				10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JOHN M. DORSEY				14. MOTHER'S MAIDEN NAME L. DORSEY, WOODSBORO, MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. MOTHER'S MAIDEN NAME Address LOUISA SMITH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X DUE TO Chronic pyelonephritis + cystitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign hypertrophy prostate DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 Aug , 19 57 , to 14 Nov , 19 57 , that I last saw the deceased alive on 13 Nov , 19 57 , and that death occurred at 3:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WALKERSVILLE, Md. DATE SIGNED 14 Nov 57							
ACTUAL SIGNATURE James E. Stoner Jr M.D.							
PHYSICIAN'S NAME (Type) JAMES E. STONER, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/17/57		22c. NAME OF CEMETERY OR CREMATORY MT. HOPE		22d. LOCATION (City, town, or county) (State) WOODSBORO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Bowell & Skutumpah, Woodsboro, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE 16 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN M. DUNN		DATE OF DEATH JAN 10 1906	
AGE 45		SEX MALE	
RACE WHITE		RELIGION METHODIST	
BIRTHPLACE MARYLAND		RESIDENCE BALTIMORE	
OCCUPATION CLOCK REPAIRER		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH HOME		SIGNATURE OF PHYSICIAN J. M. DUNN	
DATE OF BURIAL JAN 12 1906		PLACE OF BURIAL CATHOLIC CEMETERY	
NAME OF FUNERAL HOME J. M. DUNN		NAME OF MINISTER J. M. DUNN	
NAME OF UNDERTAKER J. M. DUNN		NAME OF CEMETERY CATHOLIC CEMETERY	
NAME OF FUNERAL HOME J. M. DUNN		NAME OF MINISTER J. M. DUNN	
NAME OF UNDERTAKER J. M. DUNN		NAME OF CEMETERY CATHOLIC CEMETERY	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11895

CERTIFICATE OF DEATH

11882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Thurmont		c. LENGTH OF STAY IN 1b 70 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural x/ Thurmont		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Preston Earl Favorite		4. DATE OF DEATH Month Day Year November 1 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall H. Favorite		14. MOTHER'S MAIDEN NAME Alexzenia A. Stitely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-01-6826	
17. INFORMANT Claud H. Favorite		Address Thurmont, Md. RD2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular-renal disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 1, 1952 , to Nov 1, 1957 , that I last saw the deceased alive on Oct. 31, 1957 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 11/1/57			
ACTUAL SIGNATURE M. Franklin Birch M.D.		DATE SIGNED 11/1/57	
PHYSICIAN'S NAME (Type) Dr. F. Franklin Birely			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-3-57	22c. NAME OF CEMETERY OR CREMATORY United Brethern Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager & Son		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR 5 '57		24b. REGISTRAR'S SIGNATURE Al Leach	

CERTIFICATE OF DEATH

Page 1 of 1

NAME OF DECEASED MARTIN, JAMES		AGE 70 YRS.		SEX MALE		RACE WHITE		DATE OF DEATH NOVEMBER 3, 1957	
PLACE OF DEATH HOSPITAL		CITY BOSTON		COUNTY SUFFOLK		STATE MASSACHUSETTS		MANNER OF DEATH NATURAL	
NAME OF PHYSICIAN DR. JAMES M. MARTIN		NAME OF HOSPITAL ST. MARY'S HOSPITAL		NAME OF NURSE MRS. J. M. MARTIN		NAME OF ATTENDING PHYSICIAN DR. JAMES M. MARTIN		NAME OF SECOND PHYSICIAN DR. JAMES M. MARTIN	
NAME OF FUNERAL HOME JAMES M. MARTIN		NAME OF CEMETERY ST. MARY'S CEMETERY		NAME OF MINISTER REV. JAMES M. MARTIN		NAME OF CHURCH ST. MARY'S CHURCH		NAME OF PRIEST REV. JAMES M. MARTIN	

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NAME OF DECEASED MARTIN, JAMES		AGE 70 YRS.		SEX MALE		RACE WHITE		DATE OF DEATH NOVEMBER 3, 1957	
PLACE OF DEATH HOSPITAL		CITY BOSTON		COUNTY SUFFOLK		STATE MASSACHUSETTS		MANNER OF DEATH NATURAL	
NAME OF PHYSICIAN DR. JAMES M. MARTIN		NAME OF HOSPITAL ST. MARY'S HOSPITAL		NAME OF NURSE MRS. J. M. MARTIN		NAME OF ATTENDING PHYSICIAN DR. JAMES M. MARTIN		NAME OF SECOND PHYSICIAN DR. JAMES M. MARTIN	
NAME OF FUNERAL HOME JAMES M. MARTIN		NAME OF CEMETERY ST. MARY'S CEMETERY		NAME OF MINISTER REV. JAMES M. MARTIN		NAME OF CHURCH ST. MARY'S CHURCH		NAME OF PRIEST REV. JAMES M. MARTIN	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11896 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11883

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>	c. LENGTH OF STAY IN 1b <u>x2</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1 E. Main</u>	e. 45 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charlotte Marie Fisor</u>		4. DATE OF DEATH Month Day Year <u>November 17 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lived with Brother Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>John D. Fisor</u>		14. MOTHER'S MARDEN NAME <u>Emma K. Fisor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Ross C. Fisor Thurmont Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. D. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. D. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>November 17, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 19, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moravion Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Graceham, Fredk. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Greager</u> ADDRESS <u>Thurmont. MD</u>		24a. REC'D BY REGISTRAR <u>PAIV 2 1 '57</u>	
		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH
1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15
1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. S.

NOV 21 1957

RECEIVED

NOV 17 1957
BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11884

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick Frederick Memorial Hospital Frederick County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Thurmont, R.D. # 1.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) First Harry Middle W. Last Firor		4. DATE OF DEATH Month Nov. Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/76
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Day worker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Firor		14. MOTHER'S MAIDEN NAME Amanda Lightner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Franklin Firor		Address Thurmont, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/15, 1957, to 11/16, 1957, that I last saw the deceased alive on 11/15, 1957, and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Henry V. Chase M.D.			
PHYSICIAN'S NAME (Type) Henry V. Chase			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-57	
22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE NOV 21 1957		24b. REGISTRAR'S SIGNATURE Edy G. Hickey	

CERTIFICATE OF DEATH

THIS DAY 1957

Name of Deceased		Date of Death		Place of Death	
Benjamin Elmer		12 mrs.		Baltimore, Md.	
Age		Sex		Race	
65 yrs		Male		White	
Married		Single		Widow	
Cause of Death		Immediate Cause		Underlying Cause	
Ischemic Heart Disease		Myocardial Infarction		Atherosclerosis of Coronary Arteries	
Period of Illness		Date of Admission to Hospital		Date of Discharge from Hospital	
3 weeks		10/15/57		11/10/57	
Place of Birth		Date of Birth		Place of Birth	
Baltimore, Md.		10/15/57		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 21 1957

RECEIVED

11-12-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11885

Reg. Dist. No. 131

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural Myersville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle P. Last Fisher				4. DATE OF DEATH Month Nov. Day 2, Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sawmill operator		10b. KIND OF BUSINESS OR INDUSTRY sawmill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Philip I. Fisher				14. MOTHER'S MAIDEN NAME Jane L. Guilbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-9208		17. INFORMANT Address Mrs. Mamie Fisher, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>gave rise to immediate cause (a), stating the underlying cause last.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 2-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/5/1957		22c. NAME OF CEMETERY OR CREMATORY Community Cemetery		22d. LOCATION (City, town, or county) (State) Harmony, Fred. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE 4 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

STATE OF
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

NOV 5 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11886

Reg. Dist. No. 131

11872

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 32 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 261 West Fifth Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FLORENCE Middle GERTRUDE Last FORD				4. DATE OF DEATH Month November Day 22 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 Sept 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Zedoc Summers				14. MOTHER'S MAIDEN NAME Virginia Catherine Earp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur D. Ford Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Syn +							INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1950, to Mar 22 , 1957, that I last saw the deceased alive on Mar 22 , 1957, and that death occurred at 2:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 11-25-57							
ACTUAL SIGNATURE B. O. Thomas M.D.							
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 25 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

RECEIVED

BUREAU V. S.

NOV 26 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11898

CERTIFICATE OF DEATH

Reg. Dist. No.

11887

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FANNIE Middle WAGNER Last GITTINGS		4. DATE OF DEATH Month November Day 16 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1867
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wagner		14. MOTHER'S MAIDEN NAME Emily Burgee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. David A. Adams, Buckeystown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Cardio Vascular disease DUE TO (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 16, 1927 , to Nov 16, 1957 , that I last saw the deceased alive on Nov 16, 1957 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Market Street DATE SIGNED 11/18/57 ACTUAL SIGNATURE H. F. Kline M.D. PHYSICIAN'S NAME (Type) Dr. H. F. Kline, Sr. Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR 18 Nov. 1957		24b. REGISTRAR'S SIGNATURE Clayton B. Hark	

BUREAU V. 5

1957 03 AG..

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11888

Reg. Dist. No.

11899

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont				c. LENGTH OF STAY IN IB 50 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rural Thurmont x2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ROY WEBSTER GRABLE				4. DATE OF DEATH Month Day Year Nov. 11. 1957 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April. 22. 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Contractors		11. BIRTHPLACE (State or foreign country) Frederick Co. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Grable				14. MOTHER'S MAIDEN NAME Harriette Mumford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 213-18-0727		17. INFORMANT Address Mrs May Pryor Thurmont R.D. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease Congestive type 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15 , 19 57 , to Nov 11 , 19 57 , that I last saw the deceased alive on Nov 11 , 19 57 , and that death occurred at 11:10 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James K. Gray 11-12/57 M.D.							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) James K. Gray Thurmont Md					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Nov. 14. 1957		U.B. Cemetery		Thurmont Fredk. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Raymond E. Creager Thurmont Md				24a. REC'D BY REGISTRAR DATE Nov 14 '57		24b. REGISTRAR'S SIGNATURE Overman	

CERTIFICATE OF DEATH

11-20-57

11-20-57

Robert Thompson

60 yrs

April 1957

Male

White

Single

Nov. 11, 1957

George E. Smith

11-20-57

Nov. 11, 1957

CAUSE OF DEATH: ...

IMMEDIATE CAUSE OF DEATH: ...

IMMEDIATE CAUSE OF DEATH: ...

IMMEDIATE CAUSE OF DEATH: ...

IMMEDIATE CAUSE OF DEATH: ...

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BUREAU V. S.

NOV 14 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11889

11900

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-RFD#5				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shookstown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle REUBEN Last GROVE				4. DATE OF DEATH Month November Day 26 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1866	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Grove				14. MOTHER'S MAIDEN NAME Marietta Bopst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Sallie J. Grove-Same as Item #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1930 , to Nov 26, 1957 , that I last saw the deceased alive on Nov 23, 1957 , and that death occurred at 5:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Professional Building 11/27/57							
ACTUAL SIGNATURE B. O. Thomas M.D.				PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr. Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 29 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hecks	

BUREAU V. S.

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11890**

11873

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 16mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First REGINALD Middle M. Last HARMON		4. DATE OF DEATH Month November Day 7 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1909
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Appliance	
11. BIRTHPLACE (State or foreign country) W-Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Harmon		14. MOTHER'S MAIDEN NAME May Mohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 214-10-3656	
17. INFORMANT 918 N. Market St. Mrs. Nellie Harmon; Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO multiple pulmonary emboli + severe bronchial pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) unborn		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-26 , 19 57 , to 11-7 , 19 57 , that I last saw the deceased alive on 11-7 , 19 57 , and that death occurred at 9:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Rex R. Martin		ADDRESS (Street, city or town, state) 35 E. Church St., Frederick, Md. DATE SIGNED 11-7-57	
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-57	
22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery		22d. LOCATION (City, town, or county) (State) Keyser, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR 8 Nov. 1957 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hersh	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1900		BALTIMORE, MD	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JUN 15 1925		BALTIMORE, MD	
EDUCATION		DATE OF DEATH		PLACE OF DEATH	
HIGH SCHOOL		NOV 12 1957		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		DATE OF INTERMENT		PLACE OF INTERMENT	
NONE		NOV 15 1957		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		OFFICIAL USE	
J. H. HARRIS		J. H. HARRIS		OFFICIAL USE	

BUREAU V. S.

NOV 12 1957

RECEIVED

11874

CERTIFICATE OF DEATH

11891

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Urbana</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>1 - - - - -</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>McGRATH</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary-Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>??</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard Mc Grath</u>		14. MOTHER'S MAIDEN NAME <u>Catherina Foley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>J. Frank Harris</u> Address <u>Urbana, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung, metastatic in</u> <u>163X</u> DUE TO <u>Thoracic & lumbar vertebrae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Secondary Anemia</u> (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 5, 1957</u> , to <u>Nov 9</u> , 1957, that I last saw the deceased alive on <u>Nov 8</u> , 1957, and that death occurred at <u>2:10</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>Nov 9, 1957</u>			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. <u>Frederick, Md.</u>	
PHYSICIAN'S NAME (Type) <u>B. O. Thomas</u>		Frederick, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cemetery.</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>NOV 12 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Ely G. Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 12 1957

RECEIVED

11901

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown				c. LENGTH OF STAY IN 1b year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Maurice Middle E. Haupt, Sr. Last				4. DATE OF DEATH Month 11 Day 19 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/1875	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm tenant, ret.		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob N. Haupt				14. MOTHER'S MAIDEN NAME Amanda Wise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Annie Haupt, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolus 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Generalized arteriosclerosis (c) Fractured Hip (Nov 15 1957)						INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor					
20c. TIME OF INJURY Month, Day, Year Hour (a. m.) Nov 15 1957 P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Middletown Frederick Md.	
21. I certify that I attended the deceased from Nov 15 , 1957, to Nov 19 , 1957, that I last saw the deceased alive on Nov 19 , 1957, and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE J Elmer Harp		M.D.		ADDRESS (Street, city or town, state) Middletown		DATE SIGNED 11-20-57	
PHYSICIAN'S NAME (Type) DR. J. Elmer Harp		Middletown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/22/1957		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.				24a. REC'D BY REGISTRAR DATE 23 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

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NOV 26 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11902

CERTIFICATE OF DEATH

Reg. Dist. No. 11893

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Lantz, R.D.1 Md.				c. LENGTH OF STAY IN 1b 20 Min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lantz Md. R.D.1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hayden				4. DATE OF DEATH Month Day Year 11 27 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/57		9. AGE (In years last birthday) yrs. 20	IF UNDER 1 YEAR Months Days Hours 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lantz Md. R.D.1		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Edward Hayden				14. MOTHER'S MAIDEN NAME Vera Keown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles Edward Hayden Lantz Md. R.D.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 761.5 DUE TO PREMATURE SEPARATION of Placenta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 MOS. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 NOV , 19 57 , to 27 NOV , 19 57 , that I last saw the deceased alive on — , 19 — , and that death occurred at 1:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry H. Youngs Jr		M.D. Blue Ridge Summit, Pa		DATE SIGNED Nov 29 1957			
PHYSICIAN'S NAME (Type) HARRY H. YOUNGS JR		Blue Ridge Summit, PA					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/57		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Hare				ADDRESS Waynesboro, Pa.		24a. REC'D BY REGISTRAR DATE NOV 29 57	
				24b. REGISTRAR'S SIGNATURE Paul			

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MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE TO

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BUREAU V. S.

NOV 29 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11875

CERTIFICATE OF DEATH

11894

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>16 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>E. Baltimore Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Alberta</u> Last <u>Hess</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>06</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u>00</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jasper Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-28-7327</u>		17. INFORMANT <u>Mr. Carroll C. Hess, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the cecum</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>1 1/2 yrs (19 mo)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/31</u> , 19 <u>57</u> , to <u>11/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>57</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.				DATE SIGNED <u>11/19/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> ADDRESS <u>Taneytown, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>21 Nov. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heisk</u>	

NOV 25 1957

RECEIVED

11895
 131
 Reg. Dist. No.

11903

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Yellow Springs				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O.- Frederick- Route 3				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Hoffman				4. DATE OF DEATH Month Nov. Day 28th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> UNKNOWN WIDOWED	8. DATE OF BIRTH 12-3-1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George J. Hoffman				14. MOTHER'S MAIDEN NAME Annie E. Topper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-20-2571		17. INFORMANT Mrs. Charles W. Hoffman- Rt.3-Frederick			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Nov. 26, 1957 , to Nov. 28, 1957 , that I last saw the deceased alive on Nov. 26, 1957 , and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 East Church St. DATE SIGNED							
ACTUAL SIGNATURE <i>Dr. Hamilton J. Slusher</i>				M.D. Frederick-Maryland			
PHYSICIAN'S NAME (Type) Dr. Hamilton J. Slusher				Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline & Son</i>				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 2 Dec 1957	
				24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Hark</i>			

BUREAU V. S.

DEC 3 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11876

CERTIFICATE OF DEATH

Reg. Dist. No.

11896

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Cumberland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carlisle</u> <u>75x-9</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>706 Northwest Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>C.</u> Last <u>Hoffman</u>				4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-21-88</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>1</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Stauffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10-22</u> , 19 <u>57</u> , to <u>11-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-1</u> , 19 <u>57</u> , and that death occurred at <u>1:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. A. Pearce</u> M.D.				ADDRESS (Street, city or town, state) <u>Frederick, Md</u> DATE SIGNED <u>11/1/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminister</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray E. Hoffman</u> ADDRESS <u>219 W. Hanover St Carlisle, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>Nov-1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elyahut B. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

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NOV 4 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11904

CERTIFICATE OF DEATH

11897

Reg. Dist. No.

138

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kempton				c. LENGTH OF STAY IN 1b 13 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jessie Middle Raymond Last Joines				4. DATE OF DEATH Month November Day 20 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY N. Wilksboro, N.C.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Jesse Franklin Joines				14. MOTHER'S MAIDEN NAME Nancy L. -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mrs William Gladhill, Monrovia, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior infarct of the cardiovascular disease 422.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1957 , to Nov. 30, 1957 , that I last saw the deceased alive on Nov. 19, 1957 , and that death occurred at 4:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 11/20/57	
PHYSICIAN'S NAME (Type) James P. Kerr				PHYSICIAN'S ADDRESS Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or county) (State) Clagettville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clara L. McLeary				24a. REC'D BY REGISTRAR DATE Nov. 21, 1957		24b. REGISTRAR'S SIGNATURE Raymond F. Day	

CERTIFICATE OF DEATH

11001

STATE OF MARYLAND
COUNTY OF BALTIMORE

DECEASED: JOHN J. BROWN
AGE: 65 YEARS
SEX: MALE
DATE OF DEATH: NOV 27 1957
PLACE OF DEATH: HOME
CAUSE OF DEATH: HEART DISEASE
MANNER OF DEATH: NATURAL
SIGNATURE OF PHYSICIAN: [Signature]
SIGNATURE OF CORONER: [Signature]
SIGNATURE OF DEATH REGISTRAR: [Signature]
OFFICIAL SEAL: [Seal]
BUREAU V. B. 11001

RECEIVED
NOV 27 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11877

CERTIFICATE OF DEATH

Reg. Dist. No.

11898

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 320 North Bentz Street		d. STREET ADDRESS 320 North Bentz Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nettie Gertrude Jones		4. DATE OF DEATH Nov. 24 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21-1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick-Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wilson Morrison		14. MOTHER'S MAIDEN NAME Annie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ruth Ambush		Address 320 N. Bentz Street-Fred. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cbr Cardio Renal Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-8 , 19 47 , to 11-24 , 19 57 , that I last saw the deceased alive on 11-23 , 19 57 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30 West All Saints Street- Fred. Md. DATE SIGNED			
ACTUAL SIGNATURE U. G. Bourne Jr. M.D.			
PHYSICIAN'S NAME (Type) U. G. Bourne Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-57	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks		ADDRESS 111 Frederick, Md.	
24a. REC'D BY REGISTRAR 2 Dec. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		30 yrs.		Jan 1, 1927		New York, N.Y.		New York, N.Y.		Heart Disease		Jan 1, 1957		New York, N.Y.		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Color		Height		Weight		Education		Previous Illnesses		Alcohol Consumption		Tobacco Use		Other Habits		Remarks		Remarks	
Teacher		Married		White		5' 10"		150 lbs.		High School		None		Occasional		Daily		None		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Forensic Examiner		Signature of Toxicologist		Signature of Bacteriologist		Signature of Entomologist		Signature of Other	
John Doe		Jane Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

BUREAU V. 2

DEC 3 1957

RECEIVED

11905

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville, Md.				c. LENGTH OF STAY IN 1b Walkersville, Md. x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Green St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle Ervin Last KANODE				4. DATE OF DEATH Month NOVEMBER Day 2 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1896	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 11 Days 25	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) employed by Oxx Fiber Brush		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Martin Kanode				14. MOTHER'S MAIDEN NAME Ella Nora Graser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) world was 1		17. INFORMANT Mrs Edna M. Kanode, Walkersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, sigmoid colon 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent cystitis							INTERVAL BETWEEN ONSET AND DEATH 8 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Apr. 2, 1955, to 2 Nov., 1957, that I last saw the deceased alive on 1 Nov., 1957, and that death occurred at 4 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James S. Houser, Jr.				ADDRESS (Street, city or town, state) Walkersville, Md.			
PHYSICIAN'S NAME (Type) Robert C. Houser, Jr.				DATE SIGNED 2 Nov. 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Nov. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Houser, Jr.				24a. REC'D BY REGISTRAR DATE 5 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth H. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11906

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Frederick-Rural RD#2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana			d. STREET ADDRESS Araby		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARGARET Middle REBECCA Last KANODE			4. DATE OF DEATH Month November Day 9 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Aug 1906	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George W. O'Bryan			14. MOTHER'S MAIDEN NAME Lillie Kolb		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-6516		17. INFORMANT 103 E. Patrick St., Ralph G. Kanode, Jr., Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed Skull DUE TO (c) Minutes					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision			
20c. TIME OF INJURY Hour 6 a.m. 11/16/57 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 92	
20f. (City or town) Near Urbana		20g. (County) (State) Frederick Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE B. O. Thomas			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 12 Nov 1957	
				24b. REGISTRAR'S SIGNATURE Elyabeth G. Heck	
				24c. LOCATION (City, town, or county) (State) Frederick, Maryland	

MD - MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU A. S.

NOV 13 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11901
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Frederick-Rural RD#2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana				d. STREET ADDRESS Araby			
3. NAME OF DECEASED (Type or print) First Middle Last RALPH GRAYSON KANODE				4. DATE OF DEATH Month Day Year November 9, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 13 Feb 1902		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Oil Company		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Jacob M. Kanode				14. MOTHER'S MAIDEN NAME Ella Graser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2688		17. INFORMANT 103 E. Patrick St., Ralph G. Kanode, Jr., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest</u> DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH. <u>Minutes</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto collision</u>					
20c. TIME OF INJURY Month, Day, Year Hour 6 a.m. 11/9 19 57 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 9</u>			
20f. (City or town) <u>Near Urbana</u>		(County) <u>Frederick</u>		(State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 11-12-57			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 11-13-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE <u>11/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Hech</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or other disposal.

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NOV 13 1957

BUREAU V. 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11878

CERTIFICATE OF DEATH

11902

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 911 Shawnee Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle CALVIN Last KEENEY				4. DATE OF DEATH Month November Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1888	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Office(Retired) Lime Company		10b. KIND OF BUSINESS OR INDUSTRY Maryland		9. AGE (In years last birthday) 69 yrs.	
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Keeney				14. MOTHER'S MAIDEN NAME (First name unknown) Beard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 217-07-0950		17. INFORMANT Mrs. Ruth S. Keeney, Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1945 , to Nov. 12, 1957 , that I last saw the deceased alive on Aug. 10, 1957 , and that death occurred at 8:00A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 11/14/1957							
ACTUAL SIGNATURE B. O. Thomas M.D.				North Market St., Frederick, Maryland			
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Woodsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 14 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

NOV 15 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11903

11908

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>		c. LENGTH OF STAY IN 1b <u>9 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Walkersville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>PERCY</u> Middle <u>ROY</u> Last <u>KEENEY</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heating plant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Salomon P. Keeneey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Alta Keeneey, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15</u> , 1957, to <u>Nov. 21</u> , 1957, that I last saw the deceased alive on <u>October 30</u> , 1957, and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walkersville, Maryland</u> DATE SIGNED <u>Nov 22/57</u>							
ACTUAL SIGNATURE <u>Ernest A. Dettbarn</u> M.D.				PHYSICIAN'S NAME (Type) <u>ERNEST A. DETTBARN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Mr. Woodboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>25 Nov 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

RECEIVED

11909

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>				c. LENGTH OF STAY IN 1b <u>x2 Middletown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Amelia</u> Last <u>Kefauver</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1869</u>		9. AGE (In years lost birthday) <u>88</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Horatio B. Kefauver</u>				14. MOTHER'S MAIDEN NAME <u>Mary Glessner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Roscoe Remsberg, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerous</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>suddenly</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Middletown</u>		(County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Nov 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>57</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J Elmer Harp</u>				ADDRESS (Street, city or town, state) <u>Middletown Md.</u>			
DATE SIGNED <u>11-4-57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u>				<u>Middletown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/6/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7 Nov 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. PLACE OF BIRTH [REDACTED]		5. DATE OF BIRTH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. TIME OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]	
16. SIGNATURE OF JURY [REDACTED]		17. SIGNATURE OF JUDGE [REDACTED]		18. SIGNATURE OF CLERK [REDACTED]	
19. SIGNATURE OF REGISTRAR [REDACTED]		20. SIGNATURE OF CHIEF CLERK [REDACTED]		21. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
22. SIGNATURE OF DEPUTY CLERK [REDACTED]		23. SIGNATURE OF CLERK [REDACTED]		24. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
25. SIGNATURE OF DEPUTY CLERK [REDACTED]		26. SIGNATURE OF CLERK [REDACTED]		27. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
28. SIGNATURE OF DEPUTY CLERK [REDACTED]		29. SIGNATURE OF CLERK [REDACTED]		30. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
31. SIGNATURE OF DEPUTY CLERK [REDACTED]		32. SIGNATURE OF CLERK [REDACTED]		33. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
34. SIGNATURE OF DEPUTY CLERK [REDACTED]		35. SIGNATURE OF CLERK [REDACTED]		36. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
37. SIGNATURE OF DEPUTY CLERK [REDACTED]		38. SIGNATURE OF CLERK [REDACTED]		39. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
40. SIGNATURE OF DEPUTY CLERK [REDACTED]		41. SIGNATURE OF CLERK [REDACTED]		42. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
43. SIGNATURE OF DEPUTY CLERK [REDACTED]		44. SIGNATURE OF CLERK [REDACTED]		45. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
46. SIGNATURE OF DEPUTY CLERK [REDACTED]		47. SIGNATURE OF CLERK [REDACTED]		48. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
49. SIGNATURE OF DEPUTY CLERK [REDACTED]		50. SIGNATURE OF CLERK [REDACTED]		51. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
52. SIGNATURE OF DEPUTY CLERK [REDACTED]		53. SIGNATURE OF CLERK [REDACTED]		54. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
55. SIGNATURE OF DEPUTY CLERK [REDACTED]		56. SIGNATURE OF CLERK [REDACTED]		57. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
58. SIGNATURE OF DEPUTY CLERK [REDACTED]		59. SIGNATURE OF CLERK [REDACTED]		60. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
61. SIGNATURE OF DEPUTY CLERK [REDACTED]		62. SIGNATURE OF CLERK [REDACTED]		63. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
64. SIGNATURE OF DEPUTY CLERK [REDACTED]		65. SIGNATURE OF CLERK [REDACTED]		66. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
67. SIGNATURE OF DEPUTY CLERK [REDACTED]		68. SIGNATURE OF CLERK [REDACTED]		69. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
70. SIGNATURE OF DEPUTY CLERK [REDACTED]		71. SIGNATURE OF CLERK [REDACTED]		72. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
73. SIGNATURE OF DEPUTY CLERK [REDACTED]		74. SIGNATURE OF CLERK [REDACTED]		75. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
76. SIGNATURE OF DEPUTY CLERK [REDACTED]		77. SIGNATURE OF CLERK [REDACTED]		78. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
79. SIGNATURE OF DEPUTY CLERK [REDACTED]		80. SIGNATURE OF CLERK [REDACTED]		81. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
82. SIGNATURE OF DEPUTY CLERK [REDACTED]		83. SIGNATURE OF CLERK [REDACTED]		84. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
85. SIGNATURE OF DEPUTY CLERK [REDACTED]		86. SIGNATURE OF CLERK [REDACTED]		87. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
88. SIGNATURE OF DEPUTY CLERK [REDACTED]		89. SIGNATURE OF CLERK [REDACTED]		90. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
91. SIGNATURE OF DEPUTY CLERK [REDACTED]		92. SIGNATURE OF CLERK [REDACTED]		93. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
94. SIGNATURE OF DEPUTY CLERK [REDACTED]		95. SIGNATURE OF CLERK [REDACTED]		96. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
97. SIGNATURE OF DEPUTY CLERK [REDACTED]		98. SIGNATURE OF CLERK [REDACTED]		99. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
100. SIGNATURE OF DEPUTY CLERK [REDACTED]		101. SIGNATURE OF CLERK [REDACTED]		102. SIGNATURE OF ASSISTANT CLERK [REDACTED]	

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CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days X2 Frederick ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 515 Fairview Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (ALSO KNOWN AS CATHERINE ELIZABETH KEPLINGER) KATHERINE ELIZABETH KEPLINGER				4. DATE OF DEATH November 13, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 26, 1873	
				9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Keplinger				14. MOTHER'S MAIDEN NAME Mary Herring			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Home for the Aged, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? INTERVAL BETWEEN ONSET AND DEATH 2 wks.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3 Nov , 1957, to 13 Nov , 1957, that I last saw the deceased alive on 12 Nov , 1957, and that death occurred at 2:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg., 11/13/57 DATE SIGNED ACTUAL SIGNATURE Charles H. Conley, Jr. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr. North Market Street, Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	
						22d. LOCATION (City, town, or county) (State) Middletown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR 14 Nov 1957	
						24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

11910

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 7929 Redmore Road			
3. NAME OF DECEASED (Type or print) First Peter Middle Kradz Last Kradz				4. DATE OF DEATH Month November Day 12 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1892		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Koester's Bakery		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Kradz				14. MOTHER'S MAIDEN NAME Kata Bjelis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-09-4566		17. INFORMANT Records of Victor Cullen State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 14 , 19 57 , to Nov. 12 , 19 57 , that I last saw the deceased alive on Nov. 12 , 19 57 , and that death occurred at 7:35 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE T. F. Vestal		M.D. Cullen, Md.		DATE SIGNED Nov. 12, 1957			
PHYSICIAN'S NAME (Type) T. F. Vestal							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-57		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Smith & Zeiler Inc				ADDRESS 1901 Eastern Ave		24a. REC'D BY REGISTRAR NOV 15 57 24b. REGISTRAR'S SIGNATURE W. H. H. H.	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

11911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11907

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Adamstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle LOUISE Last KRIEG			4. DATE OF DEATH Month November Day 20 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Nov 1892		9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Adamstown, Maryland	
13. FATHER'S NAME Jesse Krieg			14. MOTHER'S MAIDEN NAME Ruth Padgett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Miss Ruth A. Krieg (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 minutes					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE B. O. Thomas			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial			22b. DATE THEREOF 11-22-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE 21 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck
22d. LOCATION (City, town, or county) Frederick, Maryland			22e. (State) Maryland		

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME SEX AGE RACE BIRTH DATE BIRTH PLACE MARRIAGE DATE MARRIAGE PLACE OCCUPATION RESIDENCE DECEASED DATE DECEASED PLACE DECEASED TIME DECEASED CAUSE DECEASED DISEASE DECEASED SYMPTOMS DECEASED TREATMENT DECEASED MEDICATION DECEASED SURGERY DECEASED PATHOLOGY DECEASED ANATOMY DECEASED PHYSIOLOGY DECEASED BIOLOGY DECEASED CHEMISTRY DECEASED METALLURGY DECEASED AGRICULTURE DECEASED MECHANICS DECEASED ELECTRICITY DECEASED OPTICS DECEASED ACOUSTICS DECEASED THERMODYNAMICS DECEASED MECHANICS DECEASED ELECTRICITY DECEASED OPTICS DECEASED ACOUSTICS DECEASED THERMODYNAMICS		EXAMINER NAME SEX AGE RACE BIRTH DATE BIRTH PLACE MARRIAGE DATE MARRIAGE PLACE OCCUPATION RESIDENCE DECEASED DATE DECEASED PLACE DECEASED TIME DECEASED CAUSE DECEASED DISEASE DECEASED SYMPTOMS DECEASED TREATMENT DECEASED MEDICATION DECEASED SURGERY DECEASED PATHOLOGY DECEASED ANATOMY DECEASED PHYSIOLOGY DECEASED BIOLOGY DECEASED CHEMISTRY DECEASED METALLURGY DECEASED AGRICULTURE DECEASED MECHANICS DECEASED ELECTRICITY DECEASED OPTICS DECEASED ACOUSTICS DECEASED THERMODYNAMICS DECEASED MECHANICS DECEASED ELECTRICITY DECEASED OPTICS DECEASED ACOUSTICS DECEASED THERMODYNAMICS	
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NOV 25 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 11-27-57 at

CERTIFICATE OF DEATH

11908

Reg. Dist. No.

131

11880

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b 3 Days				d. STREET ADDRESS 119 S. Market St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 Upper College Terrace				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADA Middle ELIZABETH Last LAMPE		4. DATE OF DEATH Month November Day 18 Year 1957					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1879	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Uriah A. Lough				14. MOTHER'S MAIDEN NAME Margaret Reifsnider			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles W. Lough—Same as Item #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension INTERVAL BETWEEN ONSET AND DEATH 3 mo							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 18, 1957 , to Nov. 18, 1957 , that I last saw the deceased alive on Nov. 17, 1957 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 11/19/1957							
ACTUAL SIGNATURE A. A. Pearre M.D.							
PHYSICIAN'S NAME (Type) Dr. A. A. Pearre				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 20 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

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1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Time of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		White		1900		New York		New York		Heart Disease		1950		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
13. Occupation		14. Education		15. Marital status		16. Date of marriage		17. Date of death		18. Date of burial		19. Date of cremation		20. Date of interment		21. Date of exhumation		22. Date of reinterment		23. Date of removal		24. Date of return	
Teacher		High School		Married		1920		1950		1950		1950		1950		1950		1950		1950		1950	
25. Date of death		26. Time of death		27. Place of death		28. Date of death		29. Time of death		30. Place of death		31. Date of death		32. Time of death		33. Place of death		34. Date of death		35. Time of death		36. Place of death	
1950		10:00 AM		New York		1950		10:00 AM		New York		1950		10:00 AM		New York		1950		10:00 AM		New York	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Items 11, 12 Film G222 11-18-57 et

CERTIFICATE OF DEATH

11909

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 BRUNSWICK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAISY Middle B Last LAWSON				4. DATE OF DEATH Month NOVEMBER Day 3 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 26, 1906	
9. AGE (In years last birthday) 51 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brunswick, Maryland	
13. FATHER'S NAME JAMES H. BEARD		14. MOTHER'S MAIDEN NAME SARAH PAYNE		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HUSBAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10-25-57 TO 11-3-57	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER 25, 1957 , to NOVEMBER 3, 1957 , that I last saw the deceased alive on NOVEMBER 3, 1957 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) FREDERICK, MD. DATE SIGNED Frederick, Md.							
ACTUAL SIGNATURE A. A. Pearce		M.D. Frederick, Md.		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 5-57		22c. NAME OF CEMETERY OR CREMATORY METHODIST		22d. LOCATION (City, town, or county) (State) PETERSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Elva V. Steeter				24a. REC'D BY REGISTRAR DATE 11-5-57		24b. REGISTRAR'S SIGNATURE Eugenia H. Burke	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

See Data for

NAME OF DECEASED FREDERICK		MARRIAGE MARRIED	
DATE OF DEATH 1957		PLACE OF DEATH FREDERICK MEMORIAL HOSPITAL	
AGE 64		OCCUPATION FARMER	
SEX MALE		EDUCATION HIGH SCHOOL	
RACE WHITE		RELIGION METHODIST	
BIRTH DATE MAY 24 1900		BIRTH PLACE BALTIMORE, MARYLAND	
FATHER'S NAME JAMES H. BERRY		MOTHER'S NAME SARAH KAYE	
FATHER'S OCCUPATION FARMER		MOTHER'S OCCUPATION HOUSEWIFE	
FATHER'S BIRTH DATE MAY 24 1900		MOTHER'S BIRTH DATE MAY 24 1900	
FATHER'S BIRTH PLACE BALTIMORE, MARYLAND		MOTHER'S BIRTH PLACE BALTIMORE, MARYLAND	

CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
UNDERLYING CAUSE ARTERIO-SCLEROSIS		PRE-EXISTING DISEASES NONE	
DATE OF DEATH 1957		PLACE OF DEATH FREDERICK MEMORIAL HOSPITAL	
AGE 64		SEX MALE	
RACE WHITE		RELIGION METHODIST	

DATE OF DEATH 1957		PLACE OF DEATH FREDERICK MEMORIAL HOSPITAL	
AGE 64		SEX MALE	
RACE WHITE		RELIGION METHODIST	
FATHER'S NAME JAMES H. BERRY		MOTHER'S NAME SARAH KAYE	
FATHER'S OCCUPATION FARMER		MOTHER'S OCCUPATION HOUSEWIFE	
FATHER'S BIRTH DATE MAY 24 1900		MOTHER'S BIRTH DATE MAY 24 1900	
FATHER'S BIRTH PLACE BALTIMORE, MARYLAND		MOTHER'S BIRTH PLACE BALTIMORE, MARYLAND	

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NOV 7 1957

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11912

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11910

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural	c. LENGTH OF STAY IN lb Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Frederick-Rural RD#2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana		d. STREET ADDRESS Araby	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE ELIZABETH LINTON		4. DATE OF DEATH Month Day Year November 9, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1907
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing Factory	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Rice	
14. MOTHER'S MAIDEN NAME Ada Rebecca Aushman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-07-1148		17. INFORMANT Ralph W. Linton (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) Crush chest (c) DUE TO (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11/9/57 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 90	20f. (City or town) (County) (State) Near Urbana Frederick Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-57	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR 12 Nov 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

MEDICAL CERTIFICATION

MASSACHUSETTS STATEMENT OF HEALTH-DEATH-19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		History of Present Illness	
Family History		Social History		Physical Examination		Laboratory Examinations	
Postmortem Examination		Autopsy		Disposition of Body		Remarks	

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 NOV 13 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11913

CERTIFICATE OF DEATH

11911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First CHARLES Middle MICHAEL Last MACKLEY				4. DATE OF DEATH Nov. 17, 1957 Month 16 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87		IF UNDER 24 HRS. Months 87 Days 87 Hours 87 Min. 87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Own Store		11. BIRTHPLACE (State or foreign country) Thurmont Fredk Co Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME James C. Mackley				14. MOTHER'S MAIDEN NAME Martha Hann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-18-2959			
17. INFORMANT James H. Mackley Thurmont.				Address Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease Chr. arteriosclerotic type 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 15, 1957 to Nov. 17, 1957 , that I last saw the deceased alive on Nov. 17, 1957 , and that death occurred at 6 P.M. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont - Md DATE SIGNED 9/18/57							
ACTUAL SIGNATURE James K. Gray				M.D. Thurmont - Md			
PHYSICIAN'S NAME (Type) James K. Gray				Thurmont. MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.		22d. LOCATION (City, town, or county) (State) Thurmont. Fredk. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont MD		24a. REC'D BY REGISTRAR NOV 21 '57	
				24b. REGISTRAR'S SIGNATURE Rebecca			

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED JAMES C. MURPHY		2. SEX Male		3. AGE 38	
4. RACE White		5. DATE OF BIRTH 1919-11-15		6. DATE OF DEATH 1957-11-21	
7. PLACE OF BIRTH Baltimore, Md.		8. OCCUPATION Salesman		9. CAUSE OF DEATH Myocardial Infarction	
10. MEDICAL HISTORY Hypertension		11. PRESENT ILLNESS Chest pain, shortness of breath		12. PLACE OF DEATH Home	
13. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		14. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		15. SIGNATURE OF WITNESSES J. H. Smith, M.D.	

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NOV 21 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11914

CERTIFICATE OF DEATH

Reg. Dist. No.

11912

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Doctor Perry Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MABEL Middle MAGADLENE Last MOCK				4. DATE OF DEATH Month November Day 27 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Sept 1957	9. AGE (In years last birthday) yrs. 2 Months 23 Days	IF UNDER 1 YEAR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Harrison Mock, Sr.				14. MOTHER'S MAIDEN NAME Catherine M. Shane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Henry H. Mock, Sr. Address (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-26 , 19 57 , to 11-27 , 19 57 , that I last saw the deceased alive on 11-26 , 19 57 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. G. Bourne Jr. M.D. 30 W. All Saints St., Fred's, Md. 11-27-57							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 29 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069308XV6

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Age: <u>57</u></p>	
<p>5. Place of birth: <u>Chicago, Ill.</u></p>		<p>6. Date of death: <u>Dec 1, 1957</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. Smith</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Dec 2, 1957</u></p>		<p>12. Office of registration: <u>Manitowish</u></p>	
<p>13. Name of informant: <u>John Doe</u></p>		<p>14. Address of informant: <u>123 Main St.</u></p>	
<p>15. Name of informant: <u>John Doe</u></p>		<p>16. Address of informant: <u>123 Main St.</u></p>	
<p>17. Name of informant: <u>John Doe</u></p>		<p>18. Address of informant: <u>123 Main St.</u></p>	
<p>19. Name of informant: <u>John Doe</u></p>		<p>20. Address of informant: <u>123 Main St.</u></p>	
<p>21. Name of informant: <u>John Doe</u></p>		<p>22. Address of informant: <u>123 Main St.</u></p>	
<p>23. Name of informant: <u>John Doe</u></p>		<p>24. Address of informant: <u>123 Main St.</u></p>	
<p>25. Name of informant: <u>John Doe</u></p>		<p>26. Address of informant: <u>123 Main St.</u></p>	
<p>27. Name of informant: <u>John Doe</u></p>		<p>28. Address of informant: <u>123 Main St.</u></p>	
<p>29. Name of informant: <u>John Doe</u></p>		<p>30. Address of informant: <u>123 Main St.</u></p>	
<p>31. Name of informant: <u>John Doe</u></p>		<p>32. Address of informant: <u>123 Main St.</u></p>	
<p>33. Name of informant: <u>John Doe</u></p>		<p>34. Address of informant: <u>123 Main St.</u></p>	
<p>35. Name of informant: <u>John Doe</u></p>		<p>36. Address of informant: <u>123 Main St.</u></p>	
<p>37. Name of informant: <u>John Doe</u></p>		<p>38. Address of informant: <u>123 Main St.</u></p>	
<p>39. Name of informant: <u>John Doe</u></p>		<p>40. Address of informant: <u>123 Main St.</u></p>	
<p>41. Name of informant: <u>John Doe</u></p>		<p>42. Address of informant: <u>123 Main St.</u></p>	
<p>43. Name of informant: <u>John Doe</u></p>		<p>44. Address of informant: <u>123 Main St.</u></p>	
<p>45. Name of informant: <u>John Doe</u></p>		<p>46. Address of informant: <u>123 Main St.</u></p>	
<p>47. Name of informant: <u>John Doe</u></p>		<p>48. Address of informant: <u>123 Main St.</u></p>	
<p>49. Name of informant: <u>John Doe</u></p>		<p>50. Address of informant: <u>123 Main St.</u></p>	
<p>51. Name of informant: <u>John Doe</u></p>		<p>52. Address of informant: <u>123 Main St.</u></p>	
<p>53. Name of informant: <u>John Doe</u></p>		<p>54. Address of informant: <u>123 Main St.</u></p>	
<p>55. Name of informant: <u>John Doe</u></p>		<p>56. Address of informant: <u>123 Main St.</u></p>	
<p>57. Name of informant: <u>John Doe</u></p>		<p>58. Address of informant: <u>123 Main St.</u></p>	
<p>59. Name of informant: <u>John Doe</u></p>		<p>60. Address of informant: <u>123 Main St.</u></p>	
<p>61. Name of informant: <u>John Doe</u></p>		<p>62. Address of informant: <u>123 Main St.</u></p>	
<p>63. Name of informant: <u>John Doe</u></p>		<p>64. Address of informant: <u>123 Main St.</u></p>	
<p>65. Name of informant: <u>John Doe</u></p>		<p>66. Address of informant: <u>123 Main St.</u></p>	
<p>67. Name of informant: <u>John Doe</u></p>		<p>68. Address of informant: <u>123 Main St.</u></p>	
<p>69. Name of informant: <u>John Doe</u></p>		<p>70. Address of informant: <u>123 Main St.</u></p>	
<p>71. Name of informant: <u>John Doe</u></p>		<p>72. Address of informant: <u>123 Main St.</u></p>	
<p>73. Name of informant: <u>John Doe</u></p>		<p>74. Address of informant: <u>123 Main St.</u></p>	
<p>75. Name of informant: <u>John Doe</u></p>		<p>76. Address of informant: <u>123 Main St.</u></p>	
<p>77. Name of informant: <u>John Doe</u></p>		<p>78. Address of informant: <u>123 Main St.</u></p>	
<p>79. Name of informant: <u>John Doe</u></p>		<p>80. Address of informant: <u>123 Main St.</u></p>	
<p>81. Name of informant: <u>John Doe</u></p>		<p>82. Address of informant: <u>123 Main St.</u></p>	
<p>83. Name of informant: <u>John Doe</u></p>		<p>84. Address of informant: <u>123 Main St.</u></p>	
<p>85. Name of informant: <u>John Doe</u></p>		<p>86. Address of informant: <u>123 Main St.</u></p>	
<p>87. Name of informant: <u>John Doe</u></p>		<p>88. Address of informant: <u>123 Main St.</u></p>	
<p>89. Name of informant: <u>John Doe</u></p>		<p>90. Address of informant: <u>123 Main St.</u></p>	
<p>91. Name of informant: <u>John Doe</u></p>		<p>92. Address of informant: <u>123 Main St.</u></p>	
<p>93. Name of informant: <u>John Doe</u></p>		<p>94. Address of informant: <u>123 Main St.</u></p>	
<p>95. Name of informant: <u>John Doe</u></p>		<p>96. Address of informant: <u>123 Main St.</u></p>	
<p>97. Name of informant: <u>John Doe</u></p>		<p>98. Address of informant: <u>123 Main St.</u></p>	
<p>99. Name of informant: <u>John Doe</u></p>		<p>100. Address of informant: <u>123 Main St.</u></p>	

RECEIVED
DEC 2 1957
BUREAU V. 3

119131

11882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 3401-41</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home - 105 Pennell St</i>		d. STREET ADDRESS <i>1210 John St</i>	
3. NAME OF DECEASED (Type or print) First <i>Lena</i> Middle <i>Cristis</i> Last <i>Munoz</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>30</i> Year <i>1957</i>	
S/SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec-7-1868</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Brunswick-Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Parker</i>		14. MOTHER'S MAIDEN NAME <i>Cristis Eliza Lessor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Col. Wm. P. C. Munoz</i>		Address <i>Frederick Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>lying cause lost.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 mo.</i> <i>7 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/15</i> , 19 <i>57</i> , to <i>11/30</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11/15</i> , 19 <i>57</i> , and that death occurred at <i>5:40</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V Chase</i>		ADDRESS (Street, city or town, state) <i>4 E Church St</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		DATE SIGNED <i>12/1/57</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Buried Dec 4/57</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Greenlawn</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Steward M. M. Co</i>		ADDRESS <i>108 W York St</i>	
24a. REC'D BY REGISTRAR <i>5265</i>		24b. REGISTRAR'S SIGNATURE <i>1957</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 3 1957

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11883

CERTIFICATE OF DEATH

11914

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SYLVIA Middle ANN Last MYERS				4. DATE OF DEATH Month November Day 9 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Oct 1937	
9. AGE (In years last birthday) 20 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Office		10b. KIND OF BUSINESS OR INDUSTRY Hood College		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Joseph C. Pazdersky			
14. MOTHER'S MAIDEN NAME Amy M. Bartgis				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 213-34-8451				17. INFORMANT Address Joseph C. Pazdersky (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - Abdominal 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Ovary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exploratory Laparotomy - Nov. 8.							INTERVAL BETWEEN ONSET AND DEATH 1 yr. + 1 1/2 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 4, 1957 , to Nov. 9, 1957 , that I last saw the deceased alive on Nov. 8, 1957 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank D. Worthington				ADDRESS (Street, city or town, state) DATE SIGNED 228 N. Market St., Frederick, Md. 11-11-57			
PHYSICIAN'S NAME (Type) Frank D. Worthington, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 12 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

BUREAU V. S.

NOV 13 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11915

Reg. Dist. No. 131

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. 80 near Urbana		c. LENGTH OF STAY IN 1b Rural Buckeystown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 80 near Urbana		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Elijah Naylor		4. DATE OF DEATH Nov. 9 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19-1934
9. AGE (in years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Co. laborer		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles H. Naylor		14. MOTHER'S MAIDEN NAME Mary V. Bell Naylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Mar. 9-38 Mar. 11-53		16. SOCIAL SECURITY NO. 217-28-5733	
17. INFORMANT Mary V. Naylor		Address Rt. 4 Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture base of skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 1-2</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision	
20c. TIME OF INJURY Month, Day, Year 11/9/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 80	20f. (City or town) (County) (State) Frederick Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas Sr.		DATE SIGNED 11/12/57	
EXAMINER'S NAME (Type) B.O. Thomas Sr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 11-57	22c. NAME OF CEMETERY OR CREMATORY St. Pauls	22d. LOCATION (City, town, or county) (State) Della, Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks		24a. REC'D BY REGISTRAR 12 Nov 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
DEPT.

MARYLAND STATEMENT OF HEALTH - CONTINUING TO
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOV 13 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11884

CERTIFICATE OF DEATH

11916

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN TB 5 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 68 S. Market St.,		d. STREET ADDRESS 68 S. Market St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle W Last Neibert		4. DATE OF DEATH Month 11 Day 8 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1879
9. AGE (In years lost birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hampton Edward Saum		14. MOTHER'S MAIDEN NAME Mary Rebecca Rhodes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Ernest Stephens		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 55 , to Nov. 3 , 19 57 , that I last saw the deceased alive on OCT 15 , 19 57 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Rex R Martin		ADDRESS (Street, city or town, state) 35 E. Church Frederick Md 11884	
PHYSICIAN'S NAME (Type) REX R MARTIN		DATE SIGNED 35 E. Church Frederick Md 11884	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11-11-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE 12 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1945		MOBILE, ALABAMA		JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CONTRACTOR		1968		MEMPHIS, TENNESSEE		FEDERAL BUREAU OF INVESTIGATION		1968		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1968		MEMPHIS, TENNESSEE		DR. JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	
MANNER OF DEATH		DATE		PLACE		NAME OF CORONER		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1968		MEMPHIS, TENNESSEE		DR. JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		1968		MEMPHIS, TENNESSEE		DR. JAMES EARL RAY		1968		MEMPHIS, TENNESSEE	

BUREAU V. S.

NOV 13 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11885

11917

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LUPTON Last NEWTON				4. DATE OF DEATH Month November Day 30 , Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Jan 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Roads Commission		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George William Newton				14. MOTHER'S MAIDEN NAME Margaret A. Barry Slack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0759		17. INFORMANT Address Miss Ocale C. Wright (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		30 Nov 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-57		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 2 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

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DEC 3 1957

BUREAU V. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
TITLE: [illegible]

COMMUNAL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11916

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11918
131

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural				c. LENGTH OF STAY IN 1b Minutes			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Urbana				e. STREET ADDRESS Araby		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIE Middle VIRGINIA Last O'BRYAN				4. DATE OF DEATH Month November Day 9 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Oct 1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 74 Days 74	IF UNDER 24 HRS. Hours 74 Min. 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nimrod Kolb				14. MOTHER'S MAIDEN NAME Mary Kolb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Melvin J. O'Bryan Address (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull 816X DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of leg DUE TO (c) Fracture of leg							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision					
20c. TIME OF INJURY Month, Day, Year Hour 6 a.m. 11/9/57 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 80		20f. (City or town) (County) (State) N. Urbana Frederick Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 12 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 8

NOV 13 1957

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11919

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Montgomery COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 15 x 2.2	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia R.F.D. Lewisdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 15 x 2.2	
3. NAME OF DECEASED (Type or print) Calvin Lee Orem		4. DATE OF DEATH Month November Day 9 Year 19 57	
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1934
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willard L. Orem		14. MOTHER'S MAIDEN NAME Mary Jane Llyes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-4957	
17. INFORMANT Oland L. Molesworth Demascus, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 982x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stab-wound located Aorta DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12hr.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabin upper rt. side of chest by swich blade knife	
20c. TIME OF INJURY Month, Day, Year 9-30 II/9 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) A.M. Vets club	20f. (City or town) (County) (State) Frederick, Frederick Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> II/II/57 DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 12, 1957	22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove	22d. LOCATION (City, town, or county) (State) Purdum, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Oland L. Molesworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR 13 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



STATE OF ILLINOIS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Medical Examiner

Date of Examination

Signature of Coroner

Date of Certification

Signature of Registrar

Date of Registration

Signature of Health Officer

Date of Certification

Signature of Medical Examiner

Date of Examination

Signature of Coroner

Date of Certification

Signature of Registrar

Date of Registration

Signature of Health Officer

Date of Certification

Signature of Medical Examiner

Date of Examination

Signature of Coroner

Date of Certification

Signature of Registrar

Date of Registration

Signature of Health Officer

Date of Certification

Signature of Medical Examiner

Date of Examination

BUREAU V. S.

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
11917
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11920

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN TB 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACIE Middle PEARL Last PANGLE		4. DATE OF DEATH Month November Day 26 , Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 18, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Mirginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Ghwen		14. MOTHER'S MAIDEN NAME Jennie Wortman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Frederick N. Pangle-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) Arterial Sclerosis DUE TO (b) Myocardial Decomposition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Thrombosis INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years 70 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Edema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 26 , 19 57 , to Nov 26 , 19 57 , that I last saw the deceased alive on Nov 26 , 19 57 , and that death occurred at 3.35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Second Street DATE SIGNED 11/26/1957 ACTUAL SIGNATURE H. L. Fahrney M.D. Frederick, Maryland PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Bealsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 29 Nov. 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth B. Heide			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11918

CERTIFICATE OF DEATH

11921

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#3		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bethel Road-Near Yellow Springs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ROBERT KING PEOMROY, SR.		4. DATE OF DEATH Month Day Year November 6, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1884
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Peomroy		14. MOTHER'S MAIDEN NAME Anna Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-8861	
17. INFORMANT Mrs. Ida H. Peomroy, Frederick R.D.#3, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. , 19 53 , to Nov. 6 , 19 57 , that I last saw the deceased alive on Nov. 2 , 19 57 , and that death occurred at 6:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 11/8/1957 ACTUAL SIGNATURE H. J. Slusher M.D. PHYSICIAN'S NAME (Type) Dr. H. J. Slusher Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Woodsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 8 Nov. 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Hesk			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 1918 -
 CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH November 12, 1918	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore		COUNTY OF BIRTH Baltimore		STATE OF BIRTH Maryland		DATE OF BIRTH October 15, 1873	
OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		SINGLE		DATE OF MARRIAGE June 1, 1905	
NAME OF WIFE Mary H. Harris		AGE 40		SEX Female		RACE White		DATE OF DEATH November 12, 1918	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore		COUNTY OF BIRTH Baltimore		STATE OF BIRTH Maryland		DATE OF BIRTH November 15, 1878	
OCCUPATION Housewife		EDUCATION High School		MARRIAGE Married		SINGLE		DATE OF MARRIAGE June 1, 1905	
NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH November 12, 1918	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore		COUNTY OF BIRTH Baltimore		STATE OF BIRTH Maryland		DATE OF BIRTH October 15, 1873	
OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		SINGLE		DATE OF MARRIAGE June 1, 1905	

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 NOV 12 1918
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11887

Item 11 File G223 12-2-57 et
CERTIFICATE OF DEATH

11922

Reg. Dist. No. 13

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 70 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crutchley Nursing Home-708 N. Market St.		d. STREET ADDRESS 708 N. Market St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle M. Last Ragan		4. DATE OF DEATH Month Nov. Day 6 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. ***** <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-22-1872
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY Frederick, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ragan		14. MOTHER'S MAIDEN NAME Mary Jane O'Hara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Floyd Reside-Williamsport-Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Nov. 6 , 19 57 , to Nov. 6 , 19 57 , that I last saw the deceased alive on Nov. 6 , 19 57 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Dr. Hamilton J. Slusher M.D. 9 E. Church St. 11-6-1957 PHYSICIAN'S NAME (Type) Frederick- Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-9-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE 8 Nov. 1957
		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		Maryland		Baltimore		Heart Disease		1957		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Married		Single		Married		Single		Single		Single		Single		Single		Single		Single		Single	
Education		High School		College		University		Graduate		Postgraduate		Postgraduate		Postgraduate		Postgraduate		Postgraduate		Postgraduate		Postgraduate	
Religion		Catholic		Protestant		Jewish		Muslim		Hindu		Buddhist		Sikh		Other		Other		Other		Other	
Race		White		Black		Asian		Hispanic		Other		Other		Other		Other		Other		Other		Other	
Marital Status		Married		Single		Divorced		Widowed		Other		Other		Other		Other		Other		Other		Other	
Date of Marriage		1915		1920		1925		1930		1935		1940		1945		1950		1955		1960		1965	
Date of Divorce		1925		1930		1935		1940		1945		1950		1955		1960		1965		1970		1975	
Date of Widowhood		1940		1945		1950		1955		1960		1965		1970		1975		1980		1985		1990	
Date of Death		1957		1962		1967		1972		1977		1982		1987		1992		1997		2002		2007	
Time of Death		10:00 AM		11:00 AM		12:00 PM		1:00 PM		2:00 PM		3:00 PM		4:00 PM		5:00 PM		6:00 PM		7:00 PM		8:00 PM	
Place of Death		Home		Hospital		Nursing Home		Prison		Other		Other		Other		Other		Other		Other		Other	
Signature of Physician		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Signature of Registrar		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

RECEIVED
NOV 12 1957
BUREAU V. S.

CERTIFICATE OF DEATH

11923

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 2129 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS 757 W. Fayette St. 3Y01.4	
3. NAME OF DECEASED (Type or print) First Rasmus Middle Rasmussen Last		4. DATE OF DEATH Month November Day 1 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1900
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Cleaner	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? Norway ✓	
13. FATHER'S NAME Rasmus Rasmussen, Sr.		14. MOTHER'S MAIDEN NAME Mary Johannsen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 112-07-8086	
17. INFORMANT Records of Victor Cullen State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. _____ Month, Day, Year _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan. 3, 1952 , to Nov. 1, 1957 , that I last saw the deceased alive on Oct. 31, 1957 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T. F. Vestal		ADDRESS (Street, city or town, state) Cullen, Md.	
DATE SIGNED Nov. 1, 1957			
PHYSICIAN'S NAME (Type) T. F. Vestal			
22a. BURIAL, CREMATION, REMOVAL (Specify) Crementation		22b. DATE THEREOF 12/1/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE M. L. Creager & Sons, Thurmont Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 4 '57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

NOV 4 1957

RECEIVED

11920

CERTIFICATE OF DEATH

11924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz				c. LENGTH OF STAY IN 1b 60 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Lantz			
f. STREET ADDRESS 1				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence B. Middle Ridenour Last				4. DATE OF DEATH Month Nov. Day 10 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1891	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Ridenour				14. MOTHER'S MAIDEN NAME Mary M. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-7753		17. INFORMANT Pauline E. Ridenour Address Lantz, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease - Coronary type 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Nov. 3 , 19 57 , to Nov. 10 , 19 57 , that I last saw the deceased alive on Nov. 10 , 19 57 , and that death occurred at 6 p. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James K. Gray				ADDRESS (Street, city or town, state) Thurmont Md.		DATE SIGNED 11-11-57	
PHYSICIAN'S NAME (Type) James K. Gray							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-13-57	22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR NOV 14 '57	
				24b. REGISTRAR'S SIGNATURE Rebecca			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED STRECHER		SEX MALE		AGE 60 yrs.		DATE OF DEATH 11-13-57	
PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND	
OCCUPATION RETIRED		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED		RELATIONSHIP WIFE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		MEDICAL HISTORY HYPERTENSION	
DATE OF BIRTH 11-13-1897		PLACE OF BIRTH BALTIMORE		PARENTS FATHER: STRECHER, JOHN MOTHER: STRECHER, MARY		PREVIOUS ILLNESS HYPERTENSION	
SIGNATURE OF PHYSICIAN J. H. STRECHER		SIGNATURE OF DECEASED J. H. STRECHER		SIGNATURE OF WITNESSES J. H. STRECHER		SIGNATURE OF CLERK J. H. STRECHER	

RECEIVED
NOV 14 1957
BUREAU V. S.

11921

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTY TOWN</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>LIBERTY TOWN X2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES PATRICK RIORDAN</u>				4. DATE OF DEATH Month Day Year <u>NOV. 4 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/15/1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>CORNELIUS RIORDAN</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET O'CONNELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ANNA B. RIORDAN, LIBERTY TOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Dilatation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 6, 1957</u> , to <u>Nov 4, 1957</u> , that I last saw the deceased alive on <u>Nov 3, 1957</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D. <u>Union Bridge Md</u>				DATE SIGNED <u>11-5-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas H. Legg</u>				<u>Union Bridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST PETERS CEM</u>		22d. LOCATION (City, town, or county) (State) <u>LIBERTY TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. B. Hinkle, Union Bridge, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 8 Nov 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Eligible G. H. Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
JAMES EARL RAY		Male		White		5-22-28		6-6-68	
6. Usual Residence		7. Place of Death		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
St. Louis, Mo.		St. Louis, Mo.		Suicide		Suicide		[Signature]	
11. Signature of Registrar		12. Signature of Medical Examiner		13. Signature of Coroner		14. Signature of Burial Officer		15. Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. Date of Burial		17. Place of Burial		18. Name of Burial Place		19. Name of Funeral Home		20. Name of Undertaker	
6-10-68		St. Louis, Mo.		St. Louis, Mo.		St. Louis, Mo.		St. Louis, Mo.	
21. Name of Hospital		22. Name of Doctor		23. Name of Nurse		24. Name of Pharmacist		25. Name of Embalmer	
St. Louis Hospital		Dr. J. H. Smith		Mrs. J. H. Smith		J. H. Smith		J. H. Smith	
26. Name of Cemetery		27. Name of Grave		28. Name of Monument		29. Name of Marker		30. Name of Vault	
St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery	
31. Name of Burial Place		32. Name of Grave		33. Name of Monument		34. Name of Marker		35. Name of Vault	
St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery		St. Louis Cemetery	

BUREAU V. S.

NOV 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11926

11922

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont Rural		c. LENGTH OF STAY IN 1b 25 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
		d. STREET ADDRESS 1	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle (Feller) Last Seipler		4. DATE OF DEATH Month November Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19. 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Fellers		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs Charles Carty		Address Thurmont. R.D. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 mos. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial ischemia, diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 16 , 19 57 , to Nov. 18 , 19 57 , that I last saw the deceased alive on Nov. 18 , 19 57 , and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Franklin Birely M.D.		ADDRESS (Street, city or town, state) Thurmont Md.	
DATE SIGNED 11/19/57			
PHYSICIAN'S NAME (Type) M. Franklin Birely		Thurmont. Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21. 1957	
22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.		22d. LOCATION (City, town, or county) (State) Thurmont. Fredk. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE M.L. Creager & Son.		ADDRESS Thurmont. Md	
24a. REC'D BY REGISTRAR NOV 21 1957		24b. REGISTRAR'S SIGNATURE Creager	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11927

11888

Reg. Dist. No. 131

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b About 26 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 241 East Sixth St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Walter Kable Shank			4. DATE OF DEATH Month November Day 24 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> Single	8. DATE OF BIRTH Oct. 4- 1900		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery		11. BIRTHPLACE (State or foreign country) Frederick, Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles B. Shank			14. MOTHER'S MAIDEN NAME Sarah Catherine Aumen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-4545		17. INFORMANT Mrs. Walter Shank, 241 E. Sixth Street, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Fire engine was in motion - M.V.)</p>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Caught between the hook and ladder turntable and tractor sections			
20c. TIME OF INJURY Month, Day, Year II-24-57	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Court St.		20f. (City or town) (County) (State) Frederick Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED November 25, 1957	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-27-1957	22c. NAME OF CEMETERY OR CREMATORY Harmony Ch. Breth. Cem.		22d. LOCATION (City, town, or county) (State) Harmony Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline & Son</i>		ADDRESS Frederick-Md.		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>	
		DATE 27 Nov. 1957			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 68 1057

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11928

11923

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 1yr.-6days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home		d. STREET ADDRESS Seneca Hotel	
3. NAME OF DECEASED (Type or print) Dr. John William First Middle Last		4. DATE OF DEATH November 19, 1957 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Retired M.D.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John L. Sheetz		14. MOTHER'S MAIDEN NAME Catherine E. Kalbach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Vindabona Convalscent Home, Braddock Hgts., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480X Influenza pneumonia DUE TO (b) 480X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/16/57 , 19 57 , to 11/19 , 19 57 , that I last saw the deceased alive on 11/19 , 19 57 , and that death occurred at 10A M from the causes and on the date stated above.			
ACTUAL SIGNATURE L. R. Schoolman M.D.		ADDRESS (Street, city or town, state) 228 N. Market St. DATE SIGNED 11/19/57	
PHYSICIAN'S NAME (Type) Dr. L. R. Schoolman		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 22, 1957	22c. NAME OF CEMETERY OR CREMATORY New Oxford Cemetery	22d. LOCATION (City, town, or county) (State) New Oxford, Adams Co., Penna.
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR 20 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11924

CERTIFICATE OF DEATH

Reg. Dist. No.

11930

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norman Middle Mahlon Last Six				4. DATE OF DEATH Month November Day 7 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1890		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Six				14. MOTHER'S MAIDEN NAME Ida Stonesifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-7151		17. INFORMANT Mrs. Ruth Six, R #2, Emmitsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary heart disease - (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) several years						INTERVAL BETWEEN ONSET AND DEATH 1 hour 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2, 1957 to Nov 7, 1957 , that I last saw the deceased alive on Nov 2, 1957 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Emmitsburg Md 11-8-57 DATE SIGNED							
ACTUAL SIGNATURE W-R. Cade		PHYSICIAN'S NAME (Type) W-R. Cade					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/57		22c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery		22d. LOCATION (City, town, or county) (State) Keysville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss				ADDRESS Merwyn C. Fuss Taneytown, Md.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

11-20-54

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
MARRIED: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. 3

NOV 12 1957

RECEIVED

RECEIVED
NOV 12 1957
BALTIMORE, MD.

11889

CERTIFICATE OF DEATH

11931

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALSO KNOWN AS MOLLIE JANE SMITH MARY JANE SMITH				4. DATE OF DEATH Month November Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 9, 1886	
9. AGE (In years last birthday) yrs. 71		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME George E. Shaffer			
14. MOTHER'S MAIDEN NAME Mary E. Schultz				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. Charles W. Smith—Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebotrombosis Leg DUE TO (c) Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 2 Days 11 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1953 , to Nov 17, 1957 , that I last saw the deceased alive on Nov 17, 1957 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Third Street, Frederick, Maryland DATE SIGNED 11/19/1957							
ACTUAL SIGNATURE Thomas E. Stone				PHYSICIAN'S NAME (Type) Dr. T. E. Stone			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) (State) Frederick, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			
24a. REC'D BY REGISTRAR DATE 22 Nov 1957				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 25 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11932	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										131	
Item 18 Film 223 11-29-57										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b State d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) State Police Barracks (B) Frederick, Md.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bartonsville Rt. 6 Fred. Co. Md. d. STREET ADDRESS ***** e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Bernard Thomas Snowden			4. DATE OF DEATH Month 9 Day 12 Year 1957		5. SEX Male			6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 27-1921			9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Harry Snowden					14. MOTHER'S MAIDEN NAME Mary Bowie						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-26-5364		17. INFORMANT Harry Snowden Address Route 6 Frederick, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Alcoholism (c) Idiopathic Epilepsy (d) Spinal fluid for Alcohol 0.40										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE B.O. Thomas			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED					
EXAMINER'S NAME (Type) B.O. Thomas Sr.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Nov. 16-57		22c. NAME OF CEMETERY OR CREMATORY Bartonsville		22d. LOCATION (City, town, or county) (State) Bartonsville-Fred. Co. Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III ADDRESS Frederick, Md.					24a. REC'D BY REGISTRAR DATE 19 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck				

RECEIVED

NOV 20 1957

BUREAU V. 5

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11926 CERTIFICATE OF DEATH

11933

Reg. Dist. No.

147

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mt. Airy</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home -</u>				d. STREET ADDRESS <u>1 Rt 1 - (Sidney)</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Leo</u> Last <u>Spencer</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Waugh Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fossett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW.I + II</u>				16. SOCIAL SECURITY NO. <u>705-12-5576</u>		17. INFORMANT <u>Joseph P. Spencer</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>More than 2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <u> </u> at work <u> </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Nov.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 10</u> , 19 <u>57</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>11/30/57</u>							
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				<u>Mt. Airy, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New London</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.M. Waltz</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clarence Kunkles</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. 2

DEC 3 1957

RECEIVED

11927

CERTIFICATE OF DEATH

Reg. Dist. No. 87

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL BUNKER HILL ROAD</u>				d. STREET ADDRESS <u>BUNKER HILL ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM JACOB STRINE</u>				4. DATE OF DEATH Month Day Year <u>NOV 19 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1873</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JACOB W STRINE</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN STULTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>CARRIED STRINE</u>				Address <u>UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Debility - 450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-11-1957</u> , to <u>11-17-1957</u> , that I last saw the deceased alive on <u>11-11-1957</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Union Bridge, Maryland</u> DATE SIGNED <u>11-18-57</u>							
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Thomas H. Legg</u>				<u>Union Bridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE RURAL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler</u> ADDRESS <u>Union Bridge, Md</u>				24a. REC'D BY REGISTRAR <u>Leslie J. Repp</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

1957 00 AG-

RECEIVED

11928

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Harmony Grove		c. LENGTH OF STAY IN 1b 38 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Thomas-Sr.		4. DATE OF DEATH Month November Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> Never married WIDOWED	8. DATE OF BIRTH Jan. 19-1869
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 2 Days 5 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachariah G. Thomas		14. MOTHER'S MAIDEN NAME Louise Grove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-38-9869	
17. INFORMANT Dr. Wm. H. Thomas-Jr.		Address Jug Bridge Hill- Frederick-Md. R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis-pneumonia 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchiectasis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 7.5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1952, to _____, 11/19, 1957, that I last saw the deceased alive on _____, 11/18, 1957, and that death occurred at 12:15AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE James B. Thomas		M.D. _____ Professional Bldg. _____	
PHYSICIAN'S NAME (Type) Dr. James B. Thomas		Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-21-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son		ADDRESS Frederick-Maryland	
24a. REC'D BY REGISTRAR 20 Nov. 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED WILLIAM THOMAS SEX MALE AGE 75</p>		<p>DATE OF DEATH NOV 21 1957 PLACE OF DEATH HOME</p>	
<p>RESIDENCE 1234 E. BALTIMORE ST. BALTIMORE, MD.</p>		<p>CAUSE OF DEATH HEART DISEASE (Specify condition) CORONARY ARTERY DISEASE</p>	
<p>DATE OF BIRTH JAN 15 1882 PLACE OF BIRTH BALTIMORE, MD.</p>		<p>EDUCATION HIGH SCHOOL OCCUPATION RETIRED</p>	
<p>RELIGION METHODIST MARITAL STATUS MARRIED</p>		<p>PREVIOUS ILLNESS YES (Specify) HYPERTENSION</p>	
<p>NAME OF PHYSICIAN DR. J. H. SMITH ADDRESS 567 N. CALVERT ST. BALTIMORE, MD.</p>		<p>NAME OF FUNERAL HOME J. H. SMITH & SONS ADDRESS 123 E. BALTIMORE ST. BALTIMORE, MD.</p>	
<p>NAME OF NEXT OF KIN MRS. J. H. SMITH ADDRESS 456 N. CALVERT ST. BALTIMORE, MD.</p>		<p>NAME OF BURIAL PLACE GREENWICH CEMETERY ADDRESS 123 E. BALTIMORE ST. BALTIMORE, MD.</p>	
<p>NAME OF REGISTRAR J. H. SMITH ADDRESS 123 E. BALTIMORE ST. BALTIMORE, MD.</p>		<p>NAME OF WITNESS J. H. SMITH ADDRESS 123 E. BALTIMORE ST. BALTIMORE, MD.</p>	

BUREAU V. 2

NOV 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11890

CERTIFICATE OF DEATH

11936

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY Fredrick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md. b. COUNTY Fredrick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredrick				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fredrick Memorial Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		1. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Tammie Sue Wenzel				4. DATE OF DEATH Month Day Year Nov 24 1957			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Nov 57	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Paul Elwood Wenzel, Jr.			
14. MOTHER'S MAIDEN NAME Patricia Ann Baker				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. Paul E. Wenzel, Walkersville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.2 Oomphalocoele DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 23 NOV , 19 57 , to 24 NOV , 19 57 , that I last saw the deceased alive on 24 NOV , 19 57 , and that death occurred at 6:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D. 220 N. Market St.				DATE SIGNED 24 NOV 57			
PHYSICIAN'S NAME (Type) A. M. Powell, Jr. M.D. Fredrick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/57		22c. NAME OF CEMETERY OR CREMATORY Glade Cemetery		22d. LOCATION (City, town, or county) (State) Walkersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. C. Barton ADDRESS Walkersville, Md.				24a. REC'D BY REGISTRAR DATE 26 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

2069191XV2

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. PLACE OF BIRTH [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF PHYSICIAN [Faint text]		11. SIGNATURE OF CORONER [Faint text]		12. SIGNATURE OF WITNESSES [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF INTERMENT [Faint text]	
16. NAME OF FUNERAL HOME [Faint text]		17. NAME OF CEMETERY [Faint text]		18. NAME OF MINISTER [Faint text]	
19. NAME OF CHURCH [Faint text]		20. NAME OF SOCIETY [Faint text]		21. NAME OF ORGANIZATION [Faint text]	
22. NAME OF ASSOCIATION [Faint text]		23. NAME OF CLUB [Faint text]		24. NAME OF ORDER [Faint text]	
25. NAME OF LODGE [Faint text]		26. NAME OF TEMPLE [Faint text]		27. NAME OF HALL [Faint text]	
28. NAME OF PARLOR [Faint text]		29. NAME OF ROOM [Faint text]		30. NAME OF OFFICE [Faint text]	
31. NAME OF STORE [Faint text]		32. NAME OF FACTORY [Faint text]		33. NAME OF WORKSHOP [Faint text]	
34. NAME OF GARAGE [Faint text]		35. NAME OF SHED [Faint text]		36. NAME OF BARN [Faint text]	
37. NAME OF FARM [Faint text]		38. NAME OF RANCH [Faint text]		39. NAME OF ESTATE [Faint text]	
40. NAME OF TRACT [Faint text]		41. NAME OF LOT [Faint text]		42. NAME OF BLOCK [Faint text]	
43. NAME OF STREET [Faint text]		44. NAME OF AVENUE [Faint text]		45. NAME OF BOULEVARD [Faint text]	
46. NAME OF PARKWAY [Faint text]		47. NAME OF DRIVE [Faint text]		48. NAME OF LANE [Faint text]	
49. NAME OF ROAD [Faint text]		50. NAME OF HIGHWAY [Faint text]		51. NAME OF BRIDGE [Faint text]	
52. NAME OF TUNNEL [Faint text]		53. NAME OF CAUSEWAY [Faint text]		54. NAME OF EMBANKMENT [Faint text]	
55. NAME OF DITCH [Faint text]		56. NAME OF CREEK [Faint text]		57. NAME OF RIVER [Faint text]	
58. NAME OF LAKE [Faint text]		59. NAME OF POND [Faint text]		60. NAME OF STREAM [Faint text]	
61. NAME OF BROOK [Faint text]		62. NAME OF CREEK [Faint text]		63. NAME OF RIVER [Faint text]	
64. NAME OF LAKE [Faint text]		65. NAME OF POND [Faint text]		66. NAME OF STREAM [Faint text]	
67. NAME OF BROOK [Faint text]		68. NAME OF CREEK [Faint text]		69. NAME OF RIVER [Faint text]	
70. NAME OF LAKE [Faint text]		71. NAME OF POND [Faint text]		72. NAME OF STREAM [Faint text]	
73. NAME OF BROOK [Faint text]		74. NAME OF CREEK [Faint text]		75. NAME OF RIVER [Faint text]	
76. NAME OF LAKE [Faint text]		77. NAME OF POND [Faint text]		78. NAME OF STREAM [Faint text]	
79. NAME OF BROOK [Faint text]		80. NAME OF CREEK [Faint text]		81. NAME OF RIVER [Faint text]	
82. NAME OF LAKE [Faint text]		83. NAME OF POND [Faint text]		84. NAME OF STREAM [Faint text]	
85. NAME OF BROOK [Faint text]		86. NAME OF CREEK [Faint text]		87. NAME OF RIVER [Faint text]	
88. NAME OF LAKE [Faint text]		89. NAME OF POND [Faint text]		90. NAME OF STREAM [Faint text]	
91. NAME OF BROOK [Faint text]		92. NAME OF CREEK [Faint text]		93. NAME OF RIVER [Faint text]	
94. NAME OF LAKE [Faint text]		95. NAME OF POND [Faint text]		96. NAME OF STREAM [Faint text]	
97. NAME OF BROOK [Faint text]		98. NAME OF CREEK [Faint text]		99. NAME OF RIVER [Faint text]	
100. NAME OF LAKE [Faint text]		101. NAME OF POND [Faint text]		102. NAME OF STREAM [Faint text]	

BUREAU V. S.

NOV 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11937

Reg. Dist. No. 139

11929

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>		d. STREET ADDRESS <u>811 S. Glover St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Joseph</u> Last <u>Werner</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 6, 1916</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer & Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Packing House</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Werner</u>		14. MOTHER'S MAIDEN NAME <u>Franciska Kocent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-12-5782</u>	
17. INFORMANT <u>Records of Victor Cullen State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal hemorrhage</u> DUE TO (b) <u>Advanced Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 7</u> , 19 <u>51</u> , to <u>Nov. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 28</u> , 19 <u>57</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cullen, Md.</u> DATE SIGNED <u>Nov. 28, 1957</u>			
ACTUAL SIGNATURE <u>T. F. Vestal</u>		M.D. <u>Cullen, Md.</u>	
PHYSICIAN'S NAME (Type) <u>T. F. Vestal</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Stainslaus Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>1300 Dundalk Ave, Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marie Szalkowski</u>		ADDRESS <u>1000 S. Howard Ave</u>	
24a. REC'D BY REGISTRAR <u>DEC 4 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED	
DEC 4 1967	
BUREAU K & S	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11891

Reg. Dist. No.

11938

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS ELGER ST							
3. NAME OF DECEASED (Type or print) H. Calvin First Middle Last				4. DATE OF DEATH Nov. 21 Month Day Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 15-1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHVEL OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY CEMENT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM W WILSON				14. MOTHER'S MAIDEN NAME SUSAN HILTEBRIDGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. 213-03-1058		17. INFORMANT MRS WM WELLING Address WESTMINSTER MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Bronchial Asthma) DUE TO (c) 5 days 6 mo							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) 491X Arteriosclerotic Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 18, 1957 to Nov 21, 1957 that I last saw the deceased alive on Nov 21, 1957 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. A. Pearse M.D.				ADDRESS (Street, city or town, state) FREDERICK, MD DATE SIGNED 11/21/57			
PHYSICIAN'S NAME (Type) A A PEARRE				FREDERICK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 24-1957		22c. NAME OF CEMETERY OR CREMATORY LUTHERAN		22d. LOCATION (City, town, or county) (State) UNIONTOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE DD Hartzler ADDRESS Union Bridge, Md				24a. REC'D BY REGISTRAR DATE 26 Nov 1957		24b. REGISTRAR'S SIGNATURE Elizabeth H. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11930

CERTIFICATE OF DEATH

11939

Reg. Dist. No.

147

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt Airy</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Buffalo Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>May</u> Last <u>Wise</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>James Thomas Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Mary Slimmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. M. L. Grimes (Daughter) Rt 2 Mt Airy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 2, 1957</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Culwell</u>				ADDRESS (Street, city or town, state) <u>Mt. Airy, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				DATE SIGNED <u>Nov. 9, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wocust Grove</u>		22d. LOCATION (City, town, or county) <u>Frederick Co.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jim Walz, Winfield, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 13 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Clarice Runkley</u>	

